

Georgia Department Of Community Health
State Health Benefit Plan
Declination of Health Benefit Coverage

Please type or
print clearly in ink

I. Employee/Member		II. Department Information											
Social Security Number <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table>												Department or School System	
Last Name First Initial		Work Unit or School											
Apartment/Box/Route		When did you start working for the Department or School System?											
Street Address		<table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 25%; padding: 2px;">Month</td><td style="width: 25%; padding: 2px;">Day</td><td style="width: 25%; padding: 2px;">Year</td></tr><tr><td style="height: 20px;"></td><td></td><td></td></tr></table>	Month	Day	Year								
Month	Day	Year											
City, State		Zip Code (5-digit + 4-digit)											
County of Residence		<table border="1" style="width: 100%; border-collapse: collapse;"><tr><td colspan="3" style="padding: 2px;">Date of Birth</td></tr><tr><td style="width: 25%; padding: 2px;">Month</td><td style="width: 25%; padding: 2px;">Day</td><td style="width: 25%; padding: 2px;">Year</td></tr><tr><td style="height: 20px;"></td><td></td><td></td></tr></table>		Date of Birth			Month	Day	Year				
Date of Birth													
Month	Day	Year											
Daytime Telephone Number ()		<table border="1" style="width: 100%; border-collapse: collapse;"><tr><td colspan="2" style="padding: 2px;">Sex (Check One)</td></tr><tr><td style="width: 50%; padding: 2px;"><input type="checkbox"/> Male</td><td style="width: 50%; padding: 2px;"><input type="checkbox"/> Female</td></tr></table>		Sex (Check One)		<input type="checkbox"/> Male	<input type="checkbox"/> Female						
Sex (Check One)													
<input type="checkbox"/> Male	<input type="checkbox"/> Female												
Area Code		<div style="border: 1px solid black; padding: 10px; min-height: 100px;">Please read the Terms, Conditions, and Instructions on the back of this form. Also carefully read the statement you check below. Your signature certifies that you understand that your subsequent enrollment with the State Health Benefit Plan will be restricted.</div>											

III. Statement and Certification (Check and sign only one statement)

☐ **Ineligible Employee**

I understand I am not eligible for coverage under the State Health Benefit Plan because my job is (check one):

- ☐ part-time
- ☐ seasonal
- ☐ intermittent
- ☐ temporary
- ☐ for an emergency period only

Employee Signature

Date

Declination by New Employee

☐ As a newly eligible employee, I do not choose to enroll in any option of the State Health Benefit Plan **because of other health insurance coverage.**

☐ As a newly eligible employee, I do not choose to enroll in any option of the State Health Benefit Plan **because of other reasons.**

I understand that if I decline coverage at this time, I cannot enroll for coverage under any option of the Plan until the next Open Enrollment period except under the conditions stated on the reverse side of this form.

Employee Signature

Date

Note: Employees enrolled in the Plan transferring between school systems or departments or rehired within the same Plan Year (i.e., July 1 thru June 30) do not have the option of declining coverage during the Plan Year.

TERMS, CONDITIONS, AND INSTRUCTIONS

General Information

This form must be completed by a member/employee who declines coverage under the State Health Benefit Plan. Review the Statement and Certifications in Section III and sign the appropriate statement.

Enrollment in the State Health Benefit Plan

Enrollment in the State Health Benefit Plan is limited to the Open Enrollment Period, except under the following conditions:

- Upon employment, an employee has the opportunity to **ENROLL** for coverage to begin the first day of the month following completion of one full calendar month of employment, subject to the conditions of the Plan. See the State Health Benefit Plan booklet for pertinent conditions.
- Upon the loss of member's/employee's or dependent's health benefit coverage through Medicaid, Medicare, the group or COBRA coverage of the spouse or former spouse, a member/employee has the opportunity to **CHANGE** from Single to Family coverage provided the request is filed no later than 31 days following the event. *(Attach a letter from Medicaid, Medicare, or the spouse's or former spouse's employer giving the reason the group coverage was terminated, the type of coverage, and the date of coverage termination.)*
- Upon the acquisition of coverage under a new spouse's group plan or your spouse's employment, you may **CHANGE** to Single coverage or **DISCONTINUE** coverage provided all dependents covered under the SHBP contract are covered under the new contract. The request for the change of coverage must be filed within 31 days following the acquisition of other coverage. *(Attach a letter from the spouse's employer giving the date of employment, effective date of coverage, and name(s) of person(s) covered.)*
- Upon the acquisition of a dependent by marriage, birth, adoption, a qualified medical child support order (QMCSO) or for certain other changes in family status *(see the Eligible Dependents Section)*, a **CHANGE** from Single to Family coverage is allowed provided the request is filed no later than 31 days following the event.
- Upon the loss of all eligible dependents, a **CHANGE** from Family to Single coverage is allowed provided the request is filed no later than 90 days following the event.

Open Enrollment Period

Open Enrollment is a time each year when active employees may enroll or **Change** option or type of coverage, subject to the provisions of the Plan. Active employees who are eligible to participate in the State Health Benefit Plan shall have an annual Open Enrollment period. The Open Enrollment period consists of a 30-day period beginning no earlier than April 15 and ending no later than May 31. Each year in advance of the period, The Commissioner of the Department of Community Health will announce the exact dates.

Note: Retirees may continue coverage at the time of retirement but are not allowed to enroll for coverage.